SPECIAL DECUBITUS MATTRESS QUESTIONNAIRE

Date: _____

Recipient Name _____ DOB _____ Recipient I.D. # _____

INDIVIDUAL ANSWERS TO ALL OF THE QUESTIONS ARE REQUIRED FOR RENTAL CONSIDERATION OF PRESSURE PADS, MATTRESS OVERLAYS, AND/OR AIR FLUIDIZED SYSTEMS. These questions should be answered by the home health agency registered nurse or the attending physician; **BUT** all of the information must be reviewed and signed by the attending physician. Acceptable is either this form or a narrative format.

VENDOR must submit a copy of the sell sheet that includes product/pricing information along with a copy of the invoice for each request.

1. What is the complete diagnosis with complicating factors, eg., nutrition, mobility, caregiver?

2. Does the patient have any decubitus presently? State location and give complete description, eg., multiple stage II on trunk or pelvis or any stage III or IV.

3. Is the patient presently on a pressure-relief system or been on an ulcer treatment program for at least the last month that has included the use of a non powered pressure reducing overlay/mattress or alternating pressure pad?

4. Has there been any surgical intervention including myocutaneous flap, skin graft, or debridement? If so, give the date of surgery. _____

5. Is there currently a treatment plan in place? If so, who is carrying out the treatment plan (i.e., nursing agency)? If nursing agency, please submit:

   a. Initial assessment
   b. Education of patient and caregiver
   c. Weekly clinical assessment
   d. Turning and positioning schedule, if applicable
   e. Appropriate wound care and treatments
   f. Management of incontinence, if applicable
   g. Management of nutrition
   h. Patient/caregiver compliance

6. If no improvement, why is patient still on this product? What is the plan of care?

_____
Physician Signature

_____
Date completed